Guidelines for Assisting Localities to Provide Appropriate, Cost Efficient Services for Children and Families Served by the Comprehensive Services Act (CSA)

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I. Introduction

Health and human service delivery systems throughout the country are experiencing considerable pressure to enhance accountability and control costs. A variety of approaches have been used to accomplish these goals. In some instances, external entities such as managed care organizations have been brought in to manage utilization and cost of services. In other cases, policy makers and funding sources have chosen to work within the existing decision making structure, developing guidelines and data bases that facilitate rational planning and prudent decision making among those responsible for delivering health and human services. The Comprehensive Services Act [CSA] was enacted by the General Assembly in 1992 for the purpose of improving care for troubled and "at risk" youth and families, as well as to control the escalating cost of residential treatment for this population. While much progress has been made, concerns about the overall increase in cost as well as concerns about out-of-home placements instigated the State Executive Council to commission the Commonwealth Institute for Child and Family Studies to conduct a feasibility study. The study focused on the application of utilization management principles to the service delivery system mandated by the CSA. Data were gathered from key stakeholders including parents, providers, FAPT members, CPMT members, and the State Management Team. Based upon the data gathered from feasibility study, it is apparent that there is need and support for utilization management.

In the feasibility study it was found that even with the implementation of CSA, the gross cost for services has continued to increase. This overall increase in cost makes it necessary to continually assess the functioning of the CSA in order to improve cost-effective performance. In designing a utilization management strategy for the CSA, the State Executive Council took into account the CSA's strong emphasis on retaining responsibility and authority at the local level as well as its focus on individualized service planning. The Council has chosen a utilization management strategy that supports local empowerment and accountability through a decision support process that provides pertinent data and guidance to individuals and groups responsible for service planning. This decision support system is based on the conclusions of the feasibility study, which generated the following principles:

- Decision making authority should remain with the locality.
- Decision makers, including consumers, FAPT, and CPMT members need to have a rational basis for assessing child/family needs/strengths and matching them with the most appropriate services.
- The guidelines need to be sufficiently flexible to account for uniqueness of each locality and the current capacity of caregivers and communities to respond to children with emotional/ behavioral disorders.
- The utilization management system must strike a balance between providing responsive, appropriate services, and being sensitive to the limited resources available to meet the needs of the many children and families requiring services.
- The system should distinguish between level of placement, i.e., psychiatric hospital,

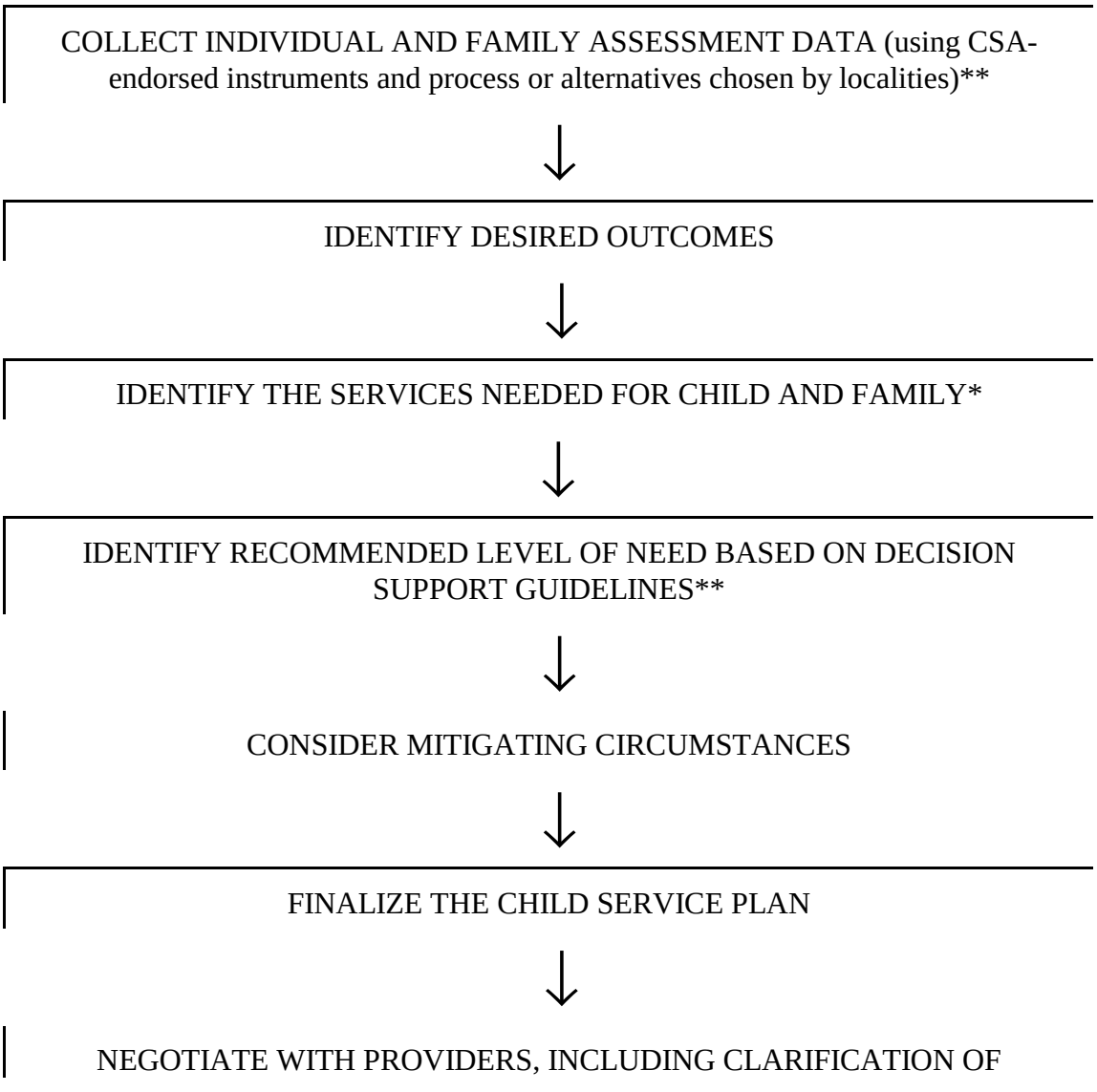
residential, group home, family, and intensity of service, with both factors being important but not necessarily interdependent. For example, for some children it is possible to provide intensive services while they remain at home, thus providing a less restrictive environment for the child while also potentially reducing the cost of services.

The following guidelines and processes have been developed to assist localities in assessing child and family needs and strengths, developing viable service plans, and implementing these plans in a responsive, cost efficient manner. In keeping with the principles of the CSA, these guidelines are not intended to provide localities with a formula-based decision making process, with rigid exclusionary criteria that result in a child being found eligible or ineligible for services. Instead, the system is designed to give decision makers a child and family-centered rational framework for assessing the most appropriate care for a given child and family. The guidelines provide a template for determining which level of need, services, and placement might be most suitable for a child and family with specific characteristics. In keeping with the child/family-centered framework, consideration of mitigating circumstances is an important part of determining the most appropriate services and placement for the child and family. These guidelines are applicable for all children who receive CSA services beyond basic maintenance for foster care children and a minimal service level. These guidelines shall, however, take into account and be applied in a manner that complies with agency requirements for specific populations, i.e., special education.

We suggest that you use these guidelines similarly to how one would use a road map. Knowing that there is a direct route to one's destination may be helpful, but having first hand knowledge of road conditions, weather, and other factors may lead one to select an alternative route which may prove to be faster, safer, and even less costly than the suggested pathway. The CSA decision support guidelines provide a framework that enables local stakeholders, including family members, to work together in a rational, accountable manner to provide responsive, cost efficient services for children. While the guidelines should facilitate this process, they are not a substitute for sound knowledge and understanding of the needs and strengths of children and families and unique conditions of local communities.

II. Summary of Utilization Management Implementation Process For Services Provided under the Comprehensive Services Act

During the 1997 budget process, the General Assembly added a requirement that all Community Policy and Management Teams [CPMTs] must incorporate utilization review of residential placements utilizing CSA funds in order to be considered for supplemental funding. For those who choose to participate in this utilization management process, the required criteria are listed below. The requirement provides local government options when considering which utilization review technology they intend to employ. Localities may choose the CSA endorsed guidelines, which are located on pages 11-16, or they can create their own guidelines that follow the criteria below. Localities also have the option of choosing how to implement the utilization review process. Those following the CSA endorsed guidelines may either manage this process on their own, or receive assistance at no cost from West Virginia Medical Institute [WVMI], the organization that provides utilization review for the Department of Medical Assistance Services. Those who choose to create their own guidelines may either manage the utilization review process internally, or contract with a utilization review organization. While the legislative requirement applies only to residential placements, localities may also conduct utilization processes for other children whose intensive and multiple needs make them appropriate for CSA services.



EXPECTATIONS FOR FAMILY INVOLVEMENT AND EXPECTATIONS FOR MONITORING OF PROGRESS

IMPLEMENT PLAN, INCLUDING PLACEMENT AT THE IDENTIFIED LEVEL OF NEED AND PROVISION OF PRESCRIBED SERVICES

PERIODIC REGULAR REVIEW OF CHILD AND FAMILY PROGRESS TOWARD TREATMENT GOALS* (after time period specified in Level of Need chart)

POSSIBLE ACTIONS AS A RESULT OF REVIEW (Repeat the **Decision Support Process**, if indicated, to assist in evaluating and revising the current plan)**:

· continue to follow the current plan
· change length of time for current service(s) and objectives
· change service objectives
· change aspects of the environment
· change provider
· change treatment modalities at same level of need
· change placement
· change level of need

*Decision Support Guidelines need to meet CSA's general criteria for decision support processes. Localities may choose from other measurement instruments that are validated and appropriate for the utilization management of child and family services (i.e., Child and Adolescent Functional Assessment Scale - CAFAS™).

**SYSTEM-LEVEL UTILIZATION MANAGEMENT: The above outlined utilization management process may be followed at both an individual level and at a larger system level. Components of the utilization management process can be compiled for all CSA cases in the locality and analyzed to review the process at the system level. Such a system level review would entail summaries of:

(a) characteristics of children and families;
(b) recommended services for CSA cases;
(c) levels of care recommended by decision support guidelines;
(d) mitigating circumstances overriding recommended level of care;
(e) decisions regarding levels of care for CSA cases;
(f) child and family progress toward treatment goals;
(g) changes in level of care as a result of review of progress.

III. Implementing a Utilization Management System at the Local Level

I. Localities wishing to receive CSA supplemental funds need to decide how they will conduct utilization review of residential placements. Localities can choose from the following options:

A. State endorsed model which includes utilization review by WVMI (illustrated on pages 5-16 of this document).

B. State endorsed model in which locality will be responsible for utilization review (illustrated on pages 5-16 of this document).

C. Locally designed model which will incorporate all utilization management criteria as outlined in this document (pages 5-10) and appropriate sections of the Code of Virginia and State Policies.

All localities participating in the utilization management process must follow the criteria of the implementation process [p.5-6].

II. Gathering individual child/family assessment data

A. Guidelines for using archival data: If the information is more than six months old, data that are not related to the child's history should be collected again.

B. Completing the assessment instruments

1. Identify a key person who is knowledgeable about the child and family, and who has a supportive relationship with them to coordinate the assessment.
2. Options for completing the instruments:
   a. Case manager or other key person completes on the basis of the child's record and his/her own knowledge.
   b. Instruments are completed by knowledgeable participants during the FAPT.
   c. Key person visits the child and his/her residence and interviews parents, caretakers, providers.
   d. Key person contacts external assessment team and coordinates interviews and records reviews.

C. Sources of information for assessment: Assessment data should reflect the perspective of children, families, current providers (including case managers), and the historical record (from the child's case record).

D. Dealing with discrepant data

1. Common sources of discrepancy
   a. Differences in child's presentation across time
   b. Differences in child's presentation across settings
   c. Differences in primary service objectives across involved parties

2. Method for resolving discrepancies
   a. Respecting the family perspective
   b. Judicious evaluation of the historical record
   c. Empowering parents as advocates

d. Negotiation over the service plan.

E. Dealing with missing data
1. Clarify a process for ensuring that all assessment data are available at the time for review and decisions.

III. What are the services required?

A. Interpreting assessment data regarding service needs
B. Engaging the family in identifying service needs
C. Negotiating level of need (frequency and intensity of services, resource investment)
D. Principles for service planning:
1. Is it what the family wants and/or does it facilitate permanency planning principles for children in foster care?
2. Is it necessary?
3. Is it a wise use of resources?
4. Does it consider the legal requirements for mandated children, i.e., foster care and special education?

IV. Analyzing and interpreting individual assessment data

A. Using the decision guidelines
1. For children with special education needs, decision support guidelines are outlined in IDEA (1997; See Attachment A)
2. For children in foster care who utilize services that are CSA funded beyond basic maintenance and a minimal service level (defined by local CPMT), decision support guidelines will be applied. For new cases, the results of the review process should be incorporated into the foster care plan reviewed and approved at the dispositional hearing by the court (under no circumstances can the use of the guidelines delay the court hearing and the action by the court on the service plan). All foster care regulations apply to all children in foster care and need to be incorporated into the CSA decision support guidelines process.
3. For all other children, identify a key person who will apply decision guidelines to assessment data to identify matching level of need
4. Clarify the process for presenting the results of the decision guidelines to child, family, FAPT and the court.
5. Clarify the process for facilitating discussion of the results of the decision guidelines that allows for airing of dissenting opinions
6. In cases where there is an IEP and a need for further services through the CSA, with parental permission the IEP can be reviewed as part of the individual assessment process. However, only the IEP committee is authorized to make changes to the IEP.

B. Using dissenting opinions to clarify potential mitigating circumstances that might influence decision guidelines
1. “Amenable to treatment?”

2. Medical needs
3. Activities of daily living (ADL) support needs
4. Child/family strengths

V. Reconciliation and decision making

A. What is involved in the decision regarding level of need?
1. CSA guidelines
2. Principles of family centered planning being consistent with principle of permanency planning for children in foster care.
3. Consideration begins at the lowest level of need
4. Principle of placement in the least restrictive environment

B. Finalize the service plan, which should include:
1. Initial level of need with corresponding review period.
2. Services the child is to receive.
3. Placement within that level of need.
4. Measurable goals/expected outcomes with timelines.
5. Step-down plan for transition to less restrictive placement, including specific discharge plans.

C. Identifying potential service providers
1. Identify key person to contact potential providers.

VI. Implementing the service plan

A. Negotiating with providers
B. Clarifying (for providers) expectations regarding family involvement in treatment planning.

VII. Monitoring progress and treatment outcomes

A. Clarifying (for providers) expectations regarding monitoring of progress
B. Identifying key person for implementing monitoring program.

VIII. Reviewing individual child level of need and service needs

A. Clarifying schedule for review of level of need and service needs
B. Clarify process for using progress/treatment outcome data in review
C. Clarify process for returning to level of need/service planning steps
D. Clarify expectations regarding step-down in level of need.

IX. Evaluating the local service system

A. Incorporating group data from decision guideline process to identify gaps in service system

B. Examining group data (by provider) to monitor quality of service
C. Examining group data by type of child/family problem (Is the system serving some kinds of children better than others?)
D. Examining group data by step-down progress (Are children moved to less restrictive settings when treatment goals are met?)

IV. Levels of Need

NOTES:

a) **The following Levels of Need chart, characteristics, and specific CAFAS™ criteria have not been proven to be an appropriate predictor of placement.** No empirical data has been gathered to confirm that this is a proven method for correct placement. It is not intended as a formula for placement, it is merely guidelines to be followed while making decisions for each case.

b) **If a child does not reach the minimal Level 1 score on the CAFAS™ (50-90), it does not mean that they can not receive services from the CSA.** These utilization management efforts are focused on the population of children who have intense needs and are involved with multiple agencies. Other children who receive early intervention and prevention services can still receive CSA services. These children are not subject to the level of need decision support process requirements.

c) **Begin consideration at the lowest Level of Need and the least restrictive placement**. A child who meets characteristics at a high level may utilize services/placement at a lower level as appropriate. Lack of expected progress should not automatically indicate movement to a higher Level of Need. All options and resources within a lower level should be tried before moving to a higher level.

d) **The minimum review period is stated as a guideline for the greatest amount of time that should pass before the reassessment of the child and family receiving services.** This review period is a suggestion and the frequency of reviews should be based on the individual needs of the child. For example, children who are in need of a change of services may require more frequent sub-reviews by the professionals responsible for the case. Persons involved in the review will vary depending on the child's level of need and placement. For children receiving services at levels 1 - 5, formal reviews will be performed periodically by FAPT or equivalent assessment teams. In addition, more frequent reviews should be conducted by the specialist responsible for the case. These evaluators are to be determined by the community responsible for the treatment plan of the child. For children receiving services at level 6, the daily evaluation should be conducted by the specialist(s) who are most familiar with the specific needs of the child.

Level of Need	Characteristics	CAFAS/PECFAS Risk Factors	CAFAS/PECFAS Total Youth/Child Score	CAFAS/PECFAS Family/Social Support Scale Score	Level Specific Program Components	Primary Caregiver Options	Minimum Review Period
1	Moderate impairment in child's functioning. · Child has emotional or behavioral problems requiring intervention which are significantly disabling and are present in several community settings. · Child needs services or resources which require coordination by at least two agencies. · Child qualifies for special education and/or is otherwise mandated for services through CSA. · Child responds positively to structure and interventions and demonstrates low risk of harm to self or others.	N/A	50-90	<20	Community-Based Interventions: · Afterschool · Respite · Mentor · Parent aide · Personal care assistance · Case management · Outpatient treatment, including family treatment · Facility-based crisis intervention (e.g., emergency or crisis shelter) · Behavior management program · Day treatment · In-home services <11 hours/week	· Parents' home · Relative's home · Foster care home · Independent living	3 months

Level	Characteristics	CAFAS/PECFAS	CAFAS/PECFAS	CAFAS/PECFAS	Level Specific Program	Primary	Minim

of Need		Risk Factors	Total Youth/Child Score	Family/Social Support Scale Score	Components	Caregiver Options	Revie Perio
2	Moderate impairment with moderate risk factors. · Needs intensive supervision to prevent harmful consequences · Moderate/frequent disruptive or noncompliant behaviors in home setting which increase risk to self or others · Needs assistance of trained professionals as caregivers	Any risk factor: CAFAS items 3, 4, 43, 68, 69, 71, 77, 78, 89, 90, 119, 142-148 PECFAS items 3, 4, 33, 65, 81, 82, 118, 150-152, 154-155	100 or higher	20 or higher	· Community-based interventions (as above) plus: · In-home services > 10 hours/week, including family focused services · Intensive partial hospitalization · Treatment foster care · Therapeutic preschool · Intensive behavior management program · Behavioral aide services	· Parents' home · Relative's home · Foster care home · Independent living · Specialized foster home · Professional treatment home	3 mon
3	Significant impairment with problems with authority, impulsivity, and caregiver issues. · Unable to handle the emotional demands of family living · Needs 24-hour immediate response to crisis behaviors · Severe disruptive peer and authority interactions that increase risk and impede growth	N/A	100 or higher and Community Scale: 30 or higher	30	Level 1 and 2 services, plus: · Therapeutic milieu with individual treatment components · Family treatment · Low-level residential placement with least restrictive educational placement and family treatment · 24 hour supervision	· Parents' home · Relative's home · Foster care home · Independent living · Specialized foster home · Professional treatment home · Group home · Crisis home · Wilderness program	2 mon
Level of Need	Characteristics	CAFAS/PECFAS Risk Factors	CAFAS/PECFAS Total Youth/Child Score	CAFAS/PECFAS Family/Social Support Scale Score	Level Specific Program Components	Primary Caregiver Options	Minim Revie Perio
4	Significant impairment with severe risk factors. · Demonstrates risk behaviors that	At least 1 severe risk factor: CAFAS items 3, 4, 71, 89, 119, 142-	140 or higher	N/A	Level 1, 2, and 3 services, plus: · Day nursing coverage · Discharge planning, from	· Parents' home · Relative's home · Foster care	1 mon

	create significant risk of harm to self or others	144 PECFAS items 3, 4, 33, 65, 81, 82, 118, 150-152			time of admission, for return to community · Intensive behavior management program	home · Independent living · Specialized foster home · Professional treatment home · Group home · Crisis home · Wilderness program · Campus-style residential treatment center · Boot camp	
Level of Need	Characteristics	CAFAS/PECFAS Risk Factors	CAFAS/PECFAS Total Youth/Child Score	CAFAS/PECFAS Family/Social Support Scale Score	Level Specific Program Components	Primary Caregiver Options	Minim Revie Perio
5	Severe impairment with severe risk factors. · Needs secure intensive treatment because of (1) demonstrated, persistent inability to be managed safely in a less structured setting (2) severe dysfunctional symptoms which require intensive interventions · Needs ready access to psychiatric care · Needs specialized programs to address symptoms and/or specific diagnostic areas	At least 1 severe risk factor in the past month: CAFAS items 3, 4, 71, 89, 119, 142-144 PECFAS items 3, 4, 33, 65, 81, 82, 118, 150-152	140 or higher	N/A	Level 1, 2, 3, and 4 services, plus: · Intensive psychiatric components (2-3 times/week), including individual and group therapy · Ready access to child psychiatrist · 24 hour direct nursing supervision · Discharge planning, from time of admission, for return to community · Intensive behavior management program	Level 1, 2, 3, and, 4 primary caregiver options, plus: · Secure residential treatment program	1 mon
6	Acute severe risk factors OR acute medical issues. · Acute risk of harm to self/others	At least 1 severe risk factor within the last 3 days:	N/A	N/A	Level 1 and 2 services, plus: Daily reassessment · Daily therapeutic treatment services	Level 1, 2, 3, 4, and 5 primary caregiver options, plus:	Daily (r factors only)

	· Requires constant observation · Other acute medical needs · Acute psychiatric issues requiring evaluation/observation	CAFAS items 3, 4, 71, 89, 119, 142-144 PECFAS items 3, 4, 33, 65, 81, 82, 118, 150-152			· Locked unit · 24 hour nursing coverage; direct medical services · Exam by psychiatrist qualified to treat children · Immediate family and community involvement · Immediate discharge planning · Psychological evaluation reviewed, updated or completed · Intensive behavior management program	· Psychiatric hospital	

V. Mitigating Circumstances to Be Considered in Placement Decisions

Mitigating circumstances may provide a rationale for selecting certain services and/or placements over others. The following list is not meant to be inclusive. Individual cases often present unique and challenging circumstances which contribute to the amazing capacity to provide community-based care. Certain mitigating circumstances may also warrant consideration of more restrictive placements than those identified after initial assessment.

System Factors

- Placement safety.
  The degree to which the placement is safe and does not present a risk of harm, neglect, or abuse for the child.
- Community safety.
  The degree to which the community would be at risk of harm from the child.
- Community capacity for WRAP.
  The degree to which the community possesses the knowledge, skills, and/or resources to provide WRAP services. WRAP services are defined as interventions that are "developed and approved by an interdisciplinary service team, are community-based, and unconditional, are centered on the strengths of the child and family, and include the delivery of coordinated, highly individualized services in three or more life domain areas of a child and family (The International Initiative on Development, Training, and Evaluation of Wraparound Services, 1992, p. 1)."
- Ability of agencies to work together.
  The degree to which multiple agencies are willing and able to coordinate services to meet the child's needs and to facilitate the child's progress.
- Community attitude towards children with serious emotional disturbances.
- Legal constraints.
- Resources of the community.

Individual Factors

- Ineffectiveness of current treatment.
- Child's unwillingness to cooperate with treatment.
- Family preferences for or against particular treatment modalities.
  Family needs and preferences must be considered in the planning and provision of services. With the exception of extenuating circumstances, the provision of services is contingent upon family acceptance. However, family and cultural preferences may preclude certain services. Refusal of services does not necessarily move the child to a higher level of need, but may warrant negotiation of different services and/or placements at the same level of need.
- Resources of the caregiver, family, and extended family.

VI. Implementing Service/Placement Decisions

Having reached a decision about the most appropriate service plan for a child, the next challenge is to identify a suitable provider and negotiate a responsive, cost effective service arrangement. Successful implementation of this phase is contingent upon at least two factors: [1] the availability of sufficient service capacity at all levels of the continuum of need, and [2] the ability to work with the provider to establish a service arrangement that responds to meet the child and family's needs/strengths while being sensitive to the importance of allocating scarce resources wisely.

Assessing Capacity

Effective utilization management requires that localities have ready access to service settings that can respond appropriately to the needs of children participating in CSA. Developing a profile of service needs of existing children currently engaged in CSA and taking an inventory of current service resources will enable a locality to determine the extent to which current service needs can be met as well as to identify existing gaps. The attached Child Service Needs/ Strengths Assessment Form in combination with the child placement decision support guidelines can be used to develop a profile of child service needs. The service description/criteria form can be used as a basis for creating an inventory of existing service capacity. This information can be used to construct a plan for developing additional needed service capacity. The plan should identify priorities for service development and strategies for creating a more complete continuum of services. New services can be created by attracting new providers to develop services, or by negotiating with existing providers to reconfigure the array of services they are able to offer.

Assuring the Provision of Responsive, Cost Effective Services for Children with Serious Emotional/ Behavioral Disorders Through Constructive Partnerships Between Localities and Providers

The purpose of this section is to assist representatives of CSA localities to become smart consumers. The likelihood of children receiving services that are appropriate to their needs/strengths and cost sensitive will be significantly increased if localities play a proactive role in defining the services they wish to purchase and working with providers to establish expectations and procedures for identifying service objectives, approving service plans, and creating processes to monitor and evaluate progress in a timely manner. Establishing clear expectations benefits children and families as well as the purchaser of service. Service providers also benefit by having clear criteria on which they can be assessed and held accountable.

By incorporating the following questions as well as others into the service negotiation process, CSA localities can become better informed and more effective purchasers of service.

- *What is the least restrictive placement that can be provided to assure safety as well as effective treatment?*

- *How does your service plan address family issues?*

- *What specific objectives need to be addressed to allow the child to move to a less restrictive placement?*

  If services are to be appropriate and efficient, we need to limit service expectations in more restrictive placements so that children can be moved to less restrictive settings where it is more appropriate for them to receive comprehensive services. While this

approach appears to fly in the face of common logic of providing comprehensive services, it has the dual benefit of shortening the length of time of children are in restrictive settings while also limiting the expenditure of unnecessary resources. [In other words, why pay more for a basic service that can be delivered just as effectively in a less restrictive, less expensive setting?]

- *What is a reasonable time frame in which to expect the specific objectives to be accomplished?*

  These objectives become, in essence, discharge criteria. Obviously, it is not possible to predict precisely how long it will take to reach the agreed upon level of improvement. Child circumstances may change, the objective that was originally established may be more difficult to achieve than initially anticipated, or may be supplanted by a more critical objective. Recognizing that we may have to alter our initial expectations, it is still useful to establish specific quantitative targets and a defined time line in order to introduce a measure of accountability into the process.

- *What methods will be used to measure progress toward objectives?*

- *What communication and reporting processes will be utilized to keep localities informed of progress and other changes, as well as to enable key stakeholders to have appropriate input into the treatment and discharge planning process?*

- *Are there financial arrangements that serve as positive incentives for both the provider and the locality in working toward treatment/discharge objectives?*

  For example, by paying providers at a case rate in which they receive a flat fee for a specified time such as three months or a year, the provider has incentive to move the child to a less restrictive placement as soon as this is appropriate. If the provider agrees to take full responsibility for the child's service, this may mitigate against providers delivering less than needed services.

- *What procedures can be put in place to ensure that planning for transfer/discharge of the child takes place early enough in the treatment process to avoid unnecessarily delays due to not having an appropriate placement available?*

  Identification of the setting and negotiating with the provider of terms and conditions should be completed prior to the time the child's emotional/behavioral status allows him/her to move.

- *Is there a sufficient review and tracking system in place to enable the locality to monitor patient function, movement, and outcome; provider performance; costs; and consumer satisfaction?*

  While there is room for individual difference among localities, it is essential to have a basic data tracking and utilization review process at both individual and aggregate levels in order to assure that resources are being used wisely.

- *Is there a proactive performance improvement process in place that engages relevant stakeholders?*

These questions are intended to serve as guidelines for communities interested in assuring that children with serious emotional/behavioral problems and their families receive services that are

responsive to their needs and strengths, appropriate for their level of functioning, and cost efficient. Given the unique nature of each locality and its relationship with service providers, the questions have deliberately been framed to allow for individual differences among localities. While it would be simpler, in some ways, to provide precise prescriptions and formulas for managing the utilization of services, we believe that allowing localities to shape processes and procedures to fit local conditions is consistent with CSA principles and ultimately yields a more viable service system for children and families. Please note that these guidelines of application at multiple levels of local CSA system. For instance, having a clear description of service objectives is critical for all stakeholders. Children need clear objectives so that they know what is expected of them and understand what it will require for them to move to a less restrictive setting. Families need to have input into service objectives because they know what children need to function well within the home. The existence of these objectives also provides families a basis for holding the service delivery system accountable. For the case manager, quantitative service objectives provide a tangible, shared reference point for discussing, evaluating, and assessing treatment progress with providers. By having explicit objectives, FAPT members are better able to track the progress of individual children as well as the performance of providers during their periodic reviews. Providers, who in some instances have been forced to establish objectives without sufficient guidance from referring agencies, will have clear lines of expectation and less risk of being mis-evaluated if there are specific objectives. Finally, CPMTs can use data about service objectives as they perform their function of developing policies and procedures that will improve the performance and cost efficiency of CSA.

A. Individuals with Disabilities Education Act [IDEA, 1997] Checklist

YES	NO	SPECIAL EDUCATION CHECKLIST The IEP includes the following as required by federal law (IDEA, 1997):
		1. A statement of the child's present level of educational performance. [Sec. 614 (d)(1)(A)(i)]
		2. A statement of measurable annual goals related to meeting the child's needs to enable the child to be involved and progress in the general curriculum. [Sec. 614 (d)(1)(A)(ii)]
		3. A statement of the special education and related services and supplementary aids to be provided to the child, or on behalf of the child. [Sec. 614 (d)(1)(A)(iii)]
		4. A statement of the program modifications or supports for school personnel that will be provided for the child to be educated and participate with other children with disabilities and nondisabled children in academic and nonacademic activities. [Sec. 614 (d)(1)(A]
		5. An explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class and in the activities described above. [Sec. 614 (d)(1)(A)(iv)]
		6. The projected date for the beginning of the services and modifications described in clause (iii), and the anticipated frequency, location, and duration of those services and modifications. [Sec. 614 (d)(1)(A)(vi)]
		7. Beginning at age 14, and updated annually, a statement of the transition service needs of the child under the applicable components of the child's IEP that focuses on the child's courses of study (such as participation in advanced placement courses or a vocational educational program); beginning at age 16 (or younger, if determined appropriate by the IEP team), a statement of the interagency responsibilities or any needed linkages; and beginning at least one year before the child reaches the age of majority under State law, a statement that the child has been informed of his or her rights under this title, if any, that will transfer to the child on reaching the age of majority under section 615(m). [Sec. 614 (d)(1)(A)(vii)]
		8. A statement of how the child's progress toward the annual goals described in clause (ii) will be measured. [Sec. 614 (d)(1)(A)(vii)(I)]
		9. In developing the child's IEP, the IEP Team has considered the strengths of the child and the concerns of the parents for enhancing their child's education. [Sec. 614 (d)(3)(A)(i)]
		10. In developing the child's IEP, the IEP Team has considered the results of the initial evaluation or the most recent evaluation of the child. [Sec. 614 (d)(3)(A)(ii)]
		11. If the child's behavior impedes his/her learning or that of others, consider appropriate strategies, including positive behavioral interventions and supports, to address the behavior. [Sec. 614 (d)(3)(B)(i)]
		12. The regular education teacher, as a member of the IEP Team, has, to the extent appropriate, participated in the development of the child's IEP. [Sec. 614 (d)(4)(A)(i)]
		13. The IEP Team reviews the child's IEP annually to determine whether the annual goals for the child are being achieved. [Sec. 614 (d)(A)(i)]
		14. The IEP Team revises the IEP as appropriate to address any lack of expected progress toward the annual goals and in the general curriculum, where appropriate. [Sec. 614 (d)(4)(A)(ii)(I)]
		15. The IEP Team revises the IEP as appropriate to address the results of any reevaluation conducted under this section. [Sec. 614 (d)(4)(A)(ii)(II)]
		16. The IEP Team revises the IEP as appropriate to address information about the child provided to, or by, the parents, as described in subsection (c)(1)(B). [Sec. 614 (d)(4)(A)(ii)(III)]
		17. The IEP Team revises the IEP as appropriate to address the child's anticipated needs and other matters. [Sec. 614 (d)(4)(A)(ii)(IV), Sec. 614 (d)(4)(A)(ii)(V)]
		18. The child is being educated in the least restrictive environment possible. [Sec. 612 (a)(5)(A)]

B. CAFAS™ Description

The Child and Adolescent Functional Assessment Scale (CAFAS™) was developed to assess the level of children and adolescent functioning in a number of areas. It measures how impaired a youth is in day-to-day functioning, secondary to behavioral, emotional, or substance use problems. It can be used at intake to link client needs with available services and can be used to assess change over time (e.g., client is rated quarterly). This 12-page scale contains a "menu" of behaviorally-oriented descriptions, from which the rater chooses those that the best describe the client. The CAFAS™ is suggested for youth 7 through 17 years old, or school-age children. The trained rater or clinician rates the youth. It is not an "administered" instrument. The amount of time that the CAFAS™ takes to complete is dependent on the case manager's knowledge of the child and the level of CAFAS™ training. The CAFAS™ usually takes between 10 and 30 minutes to complete.

The youth's most severe dysfunction within a specified time period is rated (e.g., last month, 3 months). A total score is generated, based on subscale scores for the following areas: School/Work, Home, Community, Behavior Toward Others, Moods/Emotions, Self-Harmful Behavior, Substance Use, and Thinking Problems. Scores are also generated for the youth's Caregiver on two scales: Material Needs and Family/Social Support. There are separate forms provided for the caregivers scales: primary, non-custodial, and surrogate caregiver.

General guidelines for interpreting the Total Score are given. Risk behaviors are identified. A profile sheet is included in the CAFAS™, which provides a way to summarize the youth's functioning across settings. This profile can be used in treatment planning with the family or with other members of the treatment team. The CAFAS™ requires justification of the ratings by endorsing specific behavioral items. Thus, the CAFAS™ provides a list of specific problems that can be addressed.

The Preschool and Early Childhood Functional Assessment Scale (PECFAS™) is a "downward" version of the CAFAS™ and is available for children ages 4 to 7. The PECFAS™ has the same structure, administration, domains, and clinical utility as the CAFAS™.

C. Description of Wrap Services

The International Initiative on Development, Training, and Evaluation of Wraparound Services (1992) defined Wraparound Services as interventions that are:

> *developed and approved by an interdisciplinary service team, are community-based, and unconditional, are centered on the strengths of the child and family, and include the delivery of coordinated, highly individualized services in three or more life domain areas of a child and family*. (p. 1)

The WRAP list and descriptions that follow offers an incomplete guide to facilitate WRAP planning. Individualizing services should creatively combine all types of resources for children and families - formal and informal, traditional and nontraditional.

WRAP SERVICE LIST

THERAPEUTIC
Early interventions
Counseling and Therapy Services
Home Based Services
Day Treatment
Therapeutic Nursery Program
Non-residential Emergency Services

INSTRUCTIONAL
Regular Classroom
Resource Room
Self-Contained Classroom
Special and Alternative Schools
Homebound
Related Services
Life Skills Training
Social Skills Training

HEALTH CARE
Health Promotion
Primary Care and Screening
Acute Medical Care
Chronic Medical Care
Dental Care

VOCATIONAL
Career Education
Vocational Assessment
Job Survival Skills Training
Vocational Skills Training
Work Experiences
Job Finding, Placement and Retention Services
Supported Employment
Sheltered workshops

SUSTENANCE SERVICES
Housing
Food
Clothing
Financial Services [e.g., food stamps, AFDC, Medicaid, fuel assistance, WIC, SSI]

RECREATIONAL/SOCIAL
Neighborhood Programs
After School Program
Summer Camps
Special Recreational projects
Self-help and Support Groups
Community Service
Individualized Skills Training

FAMILY
Respite Care
Parent Education and Family Support
Mediation
Family and Parent Counseling
Home Aid Services
Relatives, Friends, Spiritual Affiliations
Shelter
Therapeutic Camp

SUPERVISORY/PROTECTIVE
Diversion
Probation
Intensive Supervision Services
Outreach Detention
Post-dispositional Detention
Child Protective Services
Individual Supervisory/Support Staff
Maundering

OPERATIONAL
Assessment
Service Planning
Case Management
Advocacy
Transportation
Legal Services

WRAP SERVICE COMPONENT DEFINITIONS[1]

1. Therapeutic

Early Intervention. Frequently, parents convey their concerns to schools, health providers, and other agencies, suggesting that emotional problems may be emerging or that the child's development is not progressing appropriately. As the child gets a little older, then the school becomes both an important and logical place to identify children who are beginning to show emotional and behavioral problems.

Early intervention efforts can be home based, school based, or a combination, and may involve providing training, counseling, support, and linkage with other services. The focus should be on the child and family holistically, rather than more restricted efforts by one agency to prevent child abuse, by another to prevent emotional disturbance and by a third to prevent developmental delays, for example.

Counseling and Therapy Services. Outpatient treatment is the least intensive and most typically used intervention in the mental health field. The traditional approach is for the youngster/family to come into an office for regularly scheduled individual, group or family therapy. Appointments may also be for medication prescription and review. Outpatient treatment is provided in such diverse settings as community mental health centers, child guidance clinics, outpatient psychiatry departments of hospitals and health maintenance organizations. Such services are also frequently provided in the private offices of mental health professionals including psychiatrists, psychologists, social workers and counselors. These services have the advantages of being nonrestrictive, relatively inexpensive, flexible and adaptable. They can be used as the only intervention for youngsters or in combination with other services, both within the mental health dimension and other dimensions. Outpatient treatment may include brief counseling, individual psychotherapy, behavioral therapy, marriage and family therapy, or group therapy. Counseling and therapy interventions can focus on general issues, or specifics, such as parent training, social skill training, the provision of social support and short-term problem-solving. The particular approaches used are based on the presenting problems of the child and family and the results of an ongoing assessment process.

Home Based Services. Home based interventions represent the extreme on the dimensions of timeliness, accessibility and intensity. They are often crisis-oriented services, provided on an outreach basis to work intensively with children and families in their homes. Home based services may also be provided before a situation has reached crisis proportions for early intervention and prevention purposes. Home based programs have the following in common:

- They maintain flexible staff hours, including 24-hour service.
- Their intake and assessment process is designed to ensure that no child is left in a dangerous situation.
- They take a family focus rather than looking at individual family members as the problem.
- They reach out to families, typically going to families' homes.
- Their approach to intervention is multifaceted, including skill training, helping the family obtain necessary resources, and counseling.
- Services are delivered based on need, rather than on categorical placement of cases.
- Caseloads are kept small for each staff member.
- The length of the intervention is often limited to a brief period, typically between two and six months, although some home based programs work with families for periods of one to three

years.

- Families are followed up to assess their progress, and to evaluate the success of the program.
- They frequently operate as collaborative interagency programs.

Day Treatment and Education. Day treatment and education is a service that provides an integrated set of educational, counseling and family interventions which involve a youngster for at least five hours a day. Day treatment and education programs frequently involve collaboration between mental health and education agencies. Even where such a formal collaboration does not exist, day treatment involves an integration of educational and mental health services. There is variability in the relative emphasis on educational and mental health interventions among day treatment and education programs. In addition, day treatment and education programs may vary in intensity. The specific features of day treatment and education programs also vary from one program to another, but typically include the following components:

- Special education, generally in small classes and with a strong emphasis on individualized instruction;
- Counseling, which may include individual and group counseling approaches;
- Family services including family counseling, parent training, brief individual counseling with parents, and assistance with specific tangible needs such as transportation, housing or medical attention;
- Vocational training, particularly for adolescents;
- Crisis intervention, not only to assist students through difficult situations but to help them improve their problem solving skills;
- Skill building with an emphasis on interpersonal and problem solving skills and practical skills of everyday life;
- Behavior modification with a focus on promoting success through the use of positive reinforcement procedures; and
- Recreational therapy, art therapy and music therapy, to further aid in the social and emotional development of the youngsters.

While day treatment is often used in an attempt to avert the need for residential placement, it is also well suited as a transitional program to help youngsters move out of a residential treatment program (Friedman, 1979). Day treatment can also be used in conjunction with some residential programs, such as therapeutic foster care or therapeutic group care, to maximize the impact of both programs.

Therapeutic Day Care. Therapeutic day care programs are designed for preschool children, ages two through six, who are deemed at risk. Ideally, each day care should accommodate 25 children with a staff of four aides, one lead teacher, and one master's level psychologist or social worker.

Therapeutic day care programs provide early intervention for victims of child abuse/neglect or for children experiencing or at risk of emotional and developmental disabilities. The program is designed to develop a child's skills using a variety of activities in the basic developmental areas of language, fine motor skills, gross motor skills, cognitive and personal-social skills. (This same premise could be developed for other age groups with the programs being geared toward the child's

presenting problems, i.e., drug abuse, emotional disturbance, etc.)

Nonresidential Emergency Services. Emergency services can be viewed as a continuum of services themselves, ranging from prevention efforts through crisis stabilization services in residential settings.

Some nonresidential emergency services focus specifically on crisis prevention, identification and management. These may include educational programs to teach young people how to handle crises and to inform them of the services that are available to them. Crisis telephone lines, which are available 24 hours a day, are an important aspect of emergency services. These hotlines, whose numbers are well publicized, offer a response that youngsters can make when they are feeling overwhelmed, confused, hurt and depressed.

These services obviously must be accessible and readily available 24 hours a day, seven days a week. Emergency outpatient services should not only include crisis counseling, but also the capacity for emergency evaluations if these are needed. Such services should be closely coordinated with emergency residential services in case it is determined that a youngster is at such risk to injure him or herself or others that 24-hour care and supervision are needed.

Another important crisis/emergency service is the type of intensive and immediate home based intervention that was described earlier. The final nonresidential emergency component goes a step beyond intensive intervention in the home to actually having a counselor remain in the home on a 24 hour basis for a short period of time. This can provide an opportunity for situations to stabilize so that the need for hospitalization is diminished.

2. Instructional

Includes regular as well as special education. Special education means specifically designed instruction, at no cost to the parent, to meet the unique needs of a child with an educational disability, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.

Regular Classroom. The least restrictive instructional setting is a general education classroom in which the troubled youngster is integrated with children without handicapping conditions. In some instances, education received in a regular classroom is supplemented by related services and resource rooms.

Resource Room. A setting in which a specially trained teacher provides individualized instruction to a single child or small group of children. Resource rooms are used to supplement services provided in regular and special education classroom settings in order to enable the child with special needs to remain in the less restrictive setting of the regular school. Children are served in the resource room for only part of the regular school day, generally during times they are most vulnerable to stress. All children served in resource rooms are assigned to a regular or special education class.

Self-Contained Classroom. A setting within the regular school in which children with educational disabilities are instructed by a teacher trained in special education. Self-contained

classrooms provide more intensive supervision than general education classrooms as well as instruction tailored to the individual needs of the youngster. Children in the self-contained classrooms may move to regular classrooms as their level of functioning improves.

Special and Alternative Schools. The needs of some students are so severe and pervasive that only a very intense program with comprehensive and fully coordinated services will be effective. Although it is desirable to deliver services in the least restrictive environment, for some children removal from their regular school or home environment for a period of time may be essential for progress to occur. By definition, a special or alternative school is a program serving primarily at risk students with an intense, comprehensive specially designed approach. For some students the approach used may involve non-traditional methods and approaches.

Homebound. Intensive tutorial instruction in the student's home or in a facility should be available as an interim measure during placement transition, crisis, or suspension. This option must be a short term one.

Related Services. Developmental, corrective, and other supportive services as are required to assist a child with educational disabilities to benefit from special education. Related services include many of the services defined in other sections of the system of care such as transportation and recreation. Services such as speech pathology, audiology, and physical and occupational therapy may be offered as related services when needed. This list of related services is not exhaustive and may include other developmental, artistic or supportive services (such as artistic and cultural programs, and art, music and dance therapy), if they are required to assist a child with educational disabilities to benefit from special education.

All such related services may not be required for each individual child. Related services may include early identification and assessment of handicapping conditions and the provision of services to minimize the effects of such conditions.

3. Health Care

Health Promotion. Health promotion is group and individual education and health counseling provided by any of a variety of professionals which assists the child or youth in the development of positive health behaviors and the avoidance of health risks. To be effective it must be interactive and be delivered in multiple settings (school, home, doctor's office/clinic, religious groups, etc).

Primary Care and Screening. Primary health care has been defined as what most people use most of the time for health care. Regular comprehensive physical examinations are the cornerstone and involve assessment of the child's health status, appropriate screening tests and preventive health care services such as immunizations and testing of vision and hearing. When provided as part of a comprehensive primary health care program, separate screenings are duplicative and counterproductive. However, children who do not receive regular checkups will benefit from special periodic health screenings if appropriate follow up and referral is provided.

Acute Medical Care. Acute medical care is defined as health services provided for the care of injured or ill children including acute substance detoxification. Both emergency services and care

during recovery from the illness or injury are included. For most situations, provision of acute medical care by the primary care provider is preferable and supplies the child or youth with the most comprehensive and integrated service.

Chronic Medical Care. Providing medical care for chronic conditions and illnesses and during prolonged episodes of rehabilitation from severe injury requires that health care providers be sensitive to the entire spectrum of the individual's needs. The effects of physical limitations on psychological and social components of health, and vice versa, must be realized and the involvement of other appropriate service providers should be arranged.

Dental Care. Dental health professionals provide prophylactic and restorative care to the teeth and associated oral structures. Acute intervention and pain relief is an essential component to which all children and youth must have access as well.

4. Vocational

Career Education. Training in what the world of work is, what occupations utilize which skills, and what requirements (educational, etc) are necessary in order to secure employment in that area. Such training should be an ongoing part of the educational program for students at risk.

Vocational Assessment. An evaluation of an individual's interests, skills and ability to engage in a vocational endeavor. This evaluation may be necessary in order to determine the area of vocational education in which a child should be placed in school. For older youth, this evaluation may be required in order for agencies such as vocational rehabilitation or JTPA to train and place him/her in a job.

Job Survival Skills Training. Appropriate social and interpersonal traits are as essential to job success as is knowledge of how to do the job. Training in how to relate to fellow workers, customers, etc is frequently necessary for youth with disabilities. This training may be provided to in-school youth in vocational education work adjustment classes and to out-of-school youth by vocational rehabilitation agencies.

Vocational Skills Training. Students with disabilities must be provided job specific training in order to secure and retain employment. The area of training for an individual student should be based on the vocational evaluation as well as the availability of local employment in the chosen vocational area. Classes may be offered through the local school division for the in-school youth or the out-of-school youth through adult education courses, JTPA or DRS sponsored training options or at the community college level.

Work Experiences. Work experience allows a student to perform the skills taught in vocational training in a real employment situation. This exposure allows him/her to experience all of the ramifications of the work place. Work experience may be a part of the educational program, work release or an in-school work program. It may also be provided as an unpaid work experience or on-the-job training using the employer as the trainer. The latter forms are more often provided to older youth by adult service agencies.

Job Finding, Placement and Retention Services. Job seeking and prevocational skills training

aid the student with a disability to understand the mechanics of securing and retaining a job. Such skills training should be offered to every student as part of the secondary school curriculum, but especially to special needs students. Such training may also be secured through adult service agencies.

Supported Employment. Training of a severely disabled person in the actual job site by a job coach frequently done on a one-to-one basis. Once the job is secured, the coach works with the disabled employee until the employee can perform the required skills on his own. The job coach also trains the employee in the necessary living skills required such as how to get to the job site, how to relate to co-workers, how to manage finances, etc. Long term ongoing support is also available to aid the employee as new situations and needs arise.

5. Recreational/Social

Neighborhood Programs. A relationship with other agencies that provide recreational services on a full time or part-time basis should be established. These would include agencies such as the local parks and recreation department, YMCA, YWCA, Big Brothers/Big Sisters, Girl Scouts, Boy Scouts, schools, colleges, or churches.

After School Program. Recreational programs for children after school hours either at a school site or at a different site. These programs may be utilized by families for child care until an older family member is available to take care of the child.

Summer Camp. Programs established to provide recreational opportunities for children to participate on a daily basis during the summer when they are not in school. Camps may be either overnight or day and last from one week to ten weeks. Summer camps provide specific target skills such as athletics, music, gymnastics, etc. General camps are also conducted which provide a combination of many activities on a daily basis.

Special Recreational Projects. Activities designed with a special goal or to meet a specific need. They could be organized as either one-time activities, or as an ongoing series. A special recreational project could include co-sponsorship of community agencies. Some examples may be a wellness campaign, a safety program, or a drug free after prom party.

Self Help and Support Groups. This is a group made up of clients with some commonality in their situations making it a true peer group with discussions being led to help them assess their own personal needs and improve their self esteem.

Community Service. A dispositional alternative used by the court whereby a child is required to participate in a public service project under such condition as the court prescribes.

6. Family

Respite Care. This service would provide an approved temporary alternative placement for emotionally disturbed or behavior disordered children when a short term separation needs to occur between the child and parent. This would give both the child and parent relief from a volatile

situation which could result in physical or mental harm to them. Respite care services also may be provided in a preventive fashion to reduce stress for families with children who are at risk.

Parent Education and Family Support. Services provided to families to enable them to cope with the stresses associated with having children with emotional and behavioral disorders, and to assist them in enhancing personal and family functioning and self esteem. Parent education services assist parents to develop communication, coping and other life skills necessary for healthy and productive functioning. Family support may be provided through an agency based program or through a consumer-run organization established for the purpose of providing advocacy and support. In many instances, family support services are delivered in a group setting, although individual sessions may also be provided.

Mediation. The process by which the disputants themselves attempt to reach a mutually satisfactory agreement on issues in dispute with the assistance of a neutral party or parties. Mediation of child custody, visitation and support is an alternative to the adversarial process of litigation. It offers the parties an opportunity to manage the mutual parenting of their child(ren) with the assistance of a professional whose primary concern is the welfare of the child(ren).

Family and Parent Counseling. A face-to-face interview in which the worker provides guidance, consultation and problems solving in a helping professional relationship. It is related to marriage, family and personal adjustment problems, values clarification, personal effectiveness and other areas of counseling exclusive of counseling related to other discreet services. The client and worker would mutually discuss and agree upon necessary referrals for a more treatment oriented therapy.

Home Aid Services. This service provides intense, one-on-one assistance to children and their families in the home. Subjects of instruction could include topics such as hygiene, budgeting, marketing, meal planning and preparation, parenting skills, housekeeping, household management, and independent living and life management skills.

Relatives, friends, spiritual affiliations. It is important to assess the utilization of nontraditional services such as those that may be available through extended family, friends and other community connections that the child and family may have within their own network. These services can prove to be valuable.

Shelter. This service would provide temporary housing and meals to a child and his family until a more permanent arrangement could be made.

Therapeutic Camp. This service is appropriate for children from 6 to 18 years of age and young adults to age 22, experiencing mild, moderate or serious problems. Services include recreational, educational and vocational experiences with supervised peer interaction provided by trained, adult role models. The service may be provided during weekends throughout the year or during the 6-9 weeks in the summer. It also includes outdoor living experiences to aid in the development of coping skills and behavior control. Services which assure community and family involvement are also provided.

7. Supervisory/Protective

Diversion. An official removal of a youth from the Juvenile Justice System by referring the youth to a non-justice treatment program or simply discontinuing the case.

Probation. The conditional court supervision of adjudicated youth which includes: giving the youth a written statement of the conditions of his probation and instructions regarding the same; using suitable methods not inconsistent with the conditions imposed by the court to aid and encourage the youth to improve their conduct and condition.

Intensive Supervision Services. Intensive Supervision Services are short term pre-disposition or post-dispositional services providing high frequency of contact (more than once weekly) and close monitoring of behavior to youth in their own homes who are at high risk of committing new offenses or who have not responded to traditional supervision methods. Intensive supervision services are usually based on, but not obligated or limited to the following precepts which are intended to serve as general descriptors of such programs.

- Monitoring of locations and behaviors through schedules and curfew;
- Availability for crisis intervention, including 24-hour service;
- Provision of behavior interventions;
- Development of case specific treatment plans;
- Provision of service brokerage;
- Provision of individual, family and group counseling with emphasis on problem solving;
- Assignment of small caseloads;
- Limitation of intervention to a brief time period, typically between two to five months; and
- Follow up of families to assess their progress and to evaluate the success of the program.

Outreach Detention. A program of intensive supervision of adolescent who would otherwise be held in secure detention. The goals of the program are to ensure the juvenile's availability for court and to prevent further delinquency pending disposition. This is accomplished through the provision of direct as well as indirect services. These services are provided while the juvenile is living in his own or a surrogate home and are intended to be a pre-dispositional service. The program should have a maximum of flexibility in meeting the needs of assigned juveniles.

Individual Supervisory/ Support staff. An individual or individuals assigned to supervise/ support the child or youth no matter where he or she ends up. This effort requires a philosophy of unconditional care and the commitment to accommodate to the flexibility such a responsibility requires.

Post-Dispositional Detention. A dispositional alternative for certain juvenile offenders who may benefit from local short term confinement or who are repeat offenders who may benefit from local treatment while in a controlled setting.

Child Protective Services. Child Protective Services (CPS) are designed to protect the child at risk of abuse or neglect, re-establish a successful parent and child relationship, and allow a child to remain in their own home whenever possible. CPS consists of the identification, receipt and immediate investigation of complaints and reports of child abuse and neglect, for children under 18

years of age. It includes an immediate response on a 24 a hour day basis to a complaint of child abuse or neglect by investigating, assessing, and validating the complaint; and documenting, arranging for, and/or providing immediate and ongoing intensive social case work and group work for the child, his family, and the alleged abuser. These services may also include assistance with homemaking, parent aid and education, child care, respite care, emergency medical care, transportation, legal proceedings and other activities to protect the child.

Mentoring. Individual staff who provide support and companionship to the child and family for designated periods of time.

8. Operational

Assessment. Assessment services are sometimes referred to as diagnostic and evaluation services. They essentially involve a professional determination of the nature of an individual or family's problems, the factors contributing to them, and the assets and resources of the individual and family. On the basis of all of this information, recommendations are made for treatment and related services, if in fact such treatment and services are indicated. The role of assessment in the system for children and adolescents with emotional and behavioral problems is particularly important due to the complexity of their problems and the failure of their problems to fit into established diagnostic categories.

Assessment of severely emotionally/behaviorally disturbed youngsters must be conducted by a multidisciplinary team. This approach is based on the recognition that the multiple problems of these youngsters must be assessed in conjunction with each other in order to develop a truly meaningful intervention plan. The importance of interagency collaboration to avoid unnecessary duplication of often extensive and expensive assessment is also apparent. Assessments involve a wide range of tools and procedures. Included should be an assessment of physical health to identify any contributing medical problems, a battery of psychological tests, an assessment of intelligence and academic achievement, assessment of social and behavioral functioning, assessment of family functioning and assessment of the child's environment. These assessments shall include the assets and strengths of the child, family and environment as well as risks and deficits that may exist. Assessments should be attuned to services in the community, and should serve as the basis for the development of individualized treatment plans.

With the use of appropriate screening procedures, the comprehensive, multidisciplinary evaluations can be reserved for those children who, during the screening, appear to require more in depth evaluation or who have not succeeded in several previous interventions attempts.

Currently, there is an increasing emphasis on the need for a broad, ecological approach to assessment. Such an approach moves beyond traditional interviewing and psychological testing to also emphasize the broader environmental, educational and family contexts for the problem. Furthermore, there are data suggesting that for youngsters with very serious problems, neuropsychological and neuropsychiatric evaluations may be helpful.

While a comprehensive interdisciplinary evaluation is needed, it is recognized that each child serving agency may have specific evaluation requirements (e.g., Individualized Educational Program [IEP], Individual Treatment Plan [ITP]).

Service Planning. On the basis of the comprehensive assessment of the child and family needs, a written service plan shall be developed. The plan shall include a description of the present level of functioning, a statement of long term goals and short term objectives, and a description of the specific services to be provided as well as persons who shall be responsible for providing them. Dates for initiating services and anticipated duration and appropriate objective criteria and evaluation procedures for determining whether internal objectives are being achieved shall be noted. Reviews shall be conducted on at least an annual basis. The service plan shall be developed by an interdisciplinary, interagency team that shall include sufficient input from the family and significant others. The plan shall serve as the basis for service delivery and case management.

Although each agency may have its own specific planning requirements, i.e., Individualized Education Program (IEP) for special education programs, an overall plan incorporating medical, educational, vocational, operational, therapeutic, social, residential, and sustenance needs also should be developed. Planning should be done by an interdisciplinary team.

While the core of service planning is the development of individual plan of services for each child and family, it is critical that periodic community based planning occurs in order to assure that appropriate services are in place to meet the needs of troubled youngsters and their families within each geographic location. Service planning shall be directed by the values and guiding principles of this comprehensive community service model.

Case Management. The process by which a worker gathers information, completes an assessment and develops a service plan. Then begins the brokering services for children and their families to ensure that an adequate treatment plan is developed and implemented; review client progress, and coordinate services. Case management services provide essential linkages among child, family and agencies involved in delivering services. Case management occurs at the client, agency and service system levels. Within the comprehensive community service model, the case management function provides for the appropriate allocation of resources, access to required services, and coordination and continuity of service provision.

Advocacy. Aggressive outreach to the child and family to work with them and, on their behalf, with numerous community agencies and resources to ensure that all needed services and supports are available and accessible.

Transportation. The conveyance of individuals to and from needed community resources and facilities. This can be a direct service provided by the case worker or arrangements could be made on a public conveyance.

Legal Services. An array of services to provide legal consultation and assistance in civil matters in order to protect the client's rights and to prevent his/her exploitation.

9. Sustenance Services

Housing. Assistance to child and family in acquiring/ maintaining safe, healthy, affordable housing and obtaining necessary household furnishings. This may include minor housing modifications and repairs when client owns his home and special modifications for the deaf and blind.

Food. The provision of food supplies in order that a family has a nutritionally balanced and adequate diet. This could also include nutritional counseling and education.

Clothing. The provision of adequate clothing to protect the child from the elements and to allow the child to feel appropriately dressed among his/her peer group.

Financial Services. The provision of monetary aid to assist families with living expenses, i.e., rent, deposits, utilities, heat, medical care, medicines, furniture, food, clothing and legal issues. These services include enrollment in government entitlement programs as well as obtaining resources from other sources, such as charitable programs.

D: Guidelines for Parent and Family Involvement in the CSA Process

Involvement of families is recognized as a critical factor in effective treatment and services for children. The importance of this involvement is stressed in the Comprehensive Services Act (CSA) which mandates family involvement in service delivery and management. Since the implementation of the CSA almost four years ago, many Virginia communities have included a parent representative on their Family Assessment and Planning Teams (FAPT) and have encouraged families to attend FAPT meetings when services for their children are being discussed. However, the extent of parent involvement in the service system varies from community to community. In recent focus groups discussing the CSA, some members of FAPTs and CPMTs were enthusiastic about their experience working with parents as a team. One person stated that "involvement of parents is the greatest thing about CSA." Other members were supportive of parent involvement but expressed concern that the parents were not really being involved but were just attending FAPT meetings. Parents in focus groups also expressed differing opinions. One parent stated that in FAPT meetings they "...felt outnumbered; what we had to say didn't really matter, it was just a formality of being there." Another parent indicated that they "were amazed at how much the FAPT team could do. We felt welcome. They found many avenues we didn't know existed."

This great difference in experience is probably due in part to the newness of the concept of parent involvement to both professionals and parents, and the lack of a clear understanding of what is meant by "involvement." Involvement and "empowerment" are often used interchangeably but a growing body of literature and practice differentiates between the two. Generally, empowerment in human services refers to a process that provides clients with the knowledge, skills, and resources to control and improve their lifestyles. Clients who are empowered are able to advocate for themselves and their families, make decisions about the kind of help they need, and locate and utilize services. In children's services, family involvement is facilitated by service providers and is referred to as a partnership or a collaborative relationship between families and service providers with shared responsibilities and powers. Family involvement then relates specifically to the family's participation in the service delivery system and particularly in the planning and provision of services for their child or family.

The following are guidelines and recommendations for involving parents in a meaningful way. They have been drawn from focus groups with both professionals and parents; studies conducted with professionals and families in Virginia on family involvement; consultation with staff and members of Parents and Children Coping Together (PACCT); and the Principles of Family Involvement adopted by The Federation of Families For Children's Mental Health. Involvement of the family includes involvement of the child for whom services are being sought.

GENERAL GUIDELINES FOR FAMILY INVOLVEMENT

There are several actions agencies can take that will help families increase their ability to work in partnerships with professionals.

1. Support the establishment of a parent support group.
   Parent support groups, which have been shown to be effective vehicles for providing support and information for parents, are not widely available. Agency efforts to assist in the establishment and functioning of such a group offer obvious benefits. These groups have

been effective in helping families understand the service system, prepare for FAPT meetings, and use services effectively. In one Virginia community, there is a pilot effort to have members of a parent support group work with agency staff to orient parents seeking help for their child to the service system. They also prepare the families to participate in service planning discussions. Both families and professionals have been very enthusiastic about the outcomes of this project.

2. Educate service providers on parent involvement.
Many service providers, particularly in residential care, may be accustomed to working with agency staff instead of families. In some instances, providers may believe that the child needs to break contact with his family in order to focus his attention on the treatment program in the new placement. Visits and telephone calls may be unreasonably restricted and little effort made to involve the family in the treatment process. Among other problems, this philosophy of treatment is contrary to the CSA tenets and is not conducive to a quick return home.

3. Support cultural diversity among professional staff in the community.
Such diversity enriches all professional staff and the community. It also ensures that when desired, families can receive treatment from providers who hold similar belief systems as their own.

4. Provide flexible funds and services that can be used to meet both individualized and unplanned needs with a minimum of bureaucracy.

5. Provide an orientation for families applying for mental health services for their children.
In order for a family to participate in a meaningful way in any service provision process, they must first understand the system within which the services are being provided and the processes that are used to determine service needs. An orientation to service provision should include complete information about the following:

   a. Agencies providing services to children and their families. Family participation can be greatly enhanced by information about both public and private agencies and the kinds of services they offer.

   b.. The information gathered about a child/family. Currently, we ask families to sign release of information forms to allow access to reports such as psychological and psychiatric evaluations, school records, and social histories. Parents often do not know what kinds of information are contained in these reports.

   c. How decisions are made. Discuss with parents all the factors that affect decisions about services, i.e., child and family's needs, risk, cost, history of service use, and assessments.

   d. Service alternatives. Rarely is there only one way to meet the needs of the child and family. Families need to know the benefits and limitations of all treatment alternatives for their child. They also need to feel that professionals are open to hearing their ideas about what would help.

PARENT INVOLVEMENT IN THE SERVICE PROVISION PROCESS

In addition to the above general principles, support of family involvement is necessary at each step of the service provision process. Guidelines and methods of family involvement are given for: (1) the process of gathering information for a case review; (2) FAPT team meetings and decision making about services; and (3) evaluation of a child's progress, services rendered, and outcomes.

1. Gathering information for case review

A. Help parents and children identify strengths, problems, and solutions.
Parents are sometimes overwhelmed with "the problems" and forget about the strengths of their child, their family, and their selves. Also, they often need help with understanding the problem and thinking about the kinds of services that would be beneficial. Whether it is an aide to ride with the child on a school bus, recreational activities, treatment, or residential care, most families know little about possible services. Often, they may have heard positive reports about a service being provided to another child and hope that their child can benefit in the same way. Assistance in developing problem solving and decision making skills will help them to focus attention on the child's individual problem and the kind of services most likely to be effective.

B. Ensure that all assessments, diagnoses, and treatments are aligned with the cultural beliefs of the families.
Explore with the parents how a service will fit within their family, culture, and lifestyle. In a recent study with parents in Virginia, some of the parents who were interviewed reported discontinuing a service or treatment plan because they disagreed with the plan. None of the parents had shared this information with the treatment providers; instead, they withdrew from the service. Most of the dissatisfactions reported by these parents concerned cultural, religious, and family issues. A couple of common statements were "My family doesn't believe in that" and "it just didn't fit our family."

C. Whenever possible, have the parents work with the case manager to collect the assessments needed for the FAPT, i.e., educational and psychological evaluations, reports from previous treatment providers.
Involve parents in deciding what is to be assessed and who will do an assessment.

D. Ensure that treatment plans incorporate the strengths of the child and family.
One community reported working with a child with severe behavioral problems who through karate classes was able to learn to control his aggressiveness. The community recognized the child's interest in martial arts and used that to help accomplish the treatment goals.

E. Allow the family to take responsibility for exploring treatment alternatives.

Explain the possible treatments and services and help them to think through the kinds of questions they have about services. Encourage them to meet with service providers and tour facilities before making decisions. Once they have made a decision about the kind of service they feel will best help their child, support their decision by advocating for access to that service.

F. Help parents explore their own support system (i.e., families, friends, church) and identify ways that this system can be helpful.
Many parents have found that church members or friends are able to help in unexpected ways.

2. Making decisions about services to be provided.

For FAPT meetings:

a. Prior to the meeting, review with the parent(s) all information to be presented. Provide them with copies of reports on which the presentation is based. Be sure that parents are included in the distribution of whatever forms or written information is given to FAPT members. Frequently, parents sit in meetings and watch while the professional members of the team refer to stacks of reports on their child and family.

b. Share with the family information on regulations and cost constraints of service provision. Parents understand and accept that funds for services are not unlimited. Their expectations are usually much more realistic and less idealistic than those of professionals.

c. Whenever needed, make efforts to provide transportation and child care to allow parents to attend meetings.

d. Schedule meetings at times convenient to parents.

e. Include the parents in setting treatment goals.

3. Involve parent(s) in evaluating their child's progress during service provision and evaluating services after completion.

a. Ensure that the evaluation reflects family and cultural issues. When evaluating a child's progress, include achievements and goals that have been jointly decided with the family. When using standardized evaluation instruments, ensure that they are valid for the family's culture.

b. Ensure that information collected is only what is needed. Whatever the reason for the evaluation (program modification, monitoring a child's progress, or overall service evaluation), parents are usually happy to participate if they feel that what they have to say is valued and that questions are not unnecessarily intrusive.

c. Use evaluation processes that include the parent's assessment of a child's progress, the

benefits and problems of the service, and outcomes.

The following references provide additional information:

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